# HEALTH CARE IN TRANSITION

**INTERIM REPORT**
**of the**
**LOS ALAMOS**
**COMMUNITY HEALTH CARE ROUNDTABLE**

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## Executive Summary

The Los Alamos area has historically offered--and taken for granted--medical services unsurpassed in similarly situated communities. Since the early 1990s, however, the scene has changed to one of seemingly constant turmoil. Health care costs to both employers and consumers have risen sharply. Insurance carriers and plans have changed frequently. Providers complain they cannot make a living; some have left the community or even the practice of medicine.

The Community Health Care Roundtable (CHCR) has been exploring the Los Alamos area health care situation since January 1998. CHCR is a local group of volunteers that includes providers, consumers, and employer representatives. The group's goal is to explore system approaches to retain or enhance health care for the community. Its efforts to date have focused on determining whether and how the medical care business in the Los Alamos area is unique either in its problems or opportunities.

The health care business is a complex mixture of economic systems. It contains elements of free enterprise, private monopoly, and government programs. This mixture is full of counterproductive and economically inefficient incentives that drive up costs. Advances in medical science have improved the quality of care but have increased its cost. Fraud and malpractice litigation also increase costs. In the past two decades, those rising costs have driven an ongoing conversion from traditional indemnity insurance plans, in which individuals seek care from any willing provider, to managed care. In managed care, primary care physicians and insurance company rules largely determine the care received.

Much of the local turmoil stems from the rapid transition to managed care. This transition has been occurring nationally since the 1980s. It occurred in only a few years in the Los Alamos area because most people are covered by health care plans of a single employer, the University of California's (UC's) Los Alamos National Laboratory (LANL). When UC/LANL switched to managed care for its employees and retirees, the local health care delivery system suffered dislocations more rapidly than in other locales.

Health care providers in the Los Alamos area are under economic stress. There is no single dominant cause—nor is there likely any single cure.

Managed care reduced the rate of increase in health care costs for several years, both nationally and locally. In that respect, it has been successful. But most cost savings have now been realized and costs are starting to move rapidly upwards again. Managed care as we know it today is not a stable, sustainable system. Neither the country nor the Los Alamos community has found the answer to spiraling health care costs.

Various health care service delivery systems have been tried around the country, including employer-based, provider-based, and community-based group insurance plans, as well as direct contracting for services by employers or employer groups. Each has its own financial attractions. None has demonstrated a clear advantage over another. Although some options remain to be explored, CHCR has been unable to find or develop an approach to financing health care for the Los Alamos community that is clearly superior to the present system. And Los Alamos is not sufficiently isolated or self-contained to make any "experimental" approaches easy to implement. Another option is to let consumers pay for their own routine care and only insure for major medical needs. However, tax laws are unfavorable to this approach.

CHCR finds that Los Alamos is not fundamentally unique. However, several factors conspire to exacerbate the same fundamental problems faced by many other small-to-medium-sized communities throughout the country. Los Alamos people use medical services, particularly specialists, more than do their counterparts in other communities. Overhead costs for medical practices in Los Alamos itself appear to be higher than national averages. New Mexico is the only state that taxes (through the approximately 6% gross receipts tax) many medical service transactions. All these factors combine to squeeze provider incomes to a level lower than national averages in an area where the cost of living is well above average. Economics is not the only basis upon which providers choose where to practice, but it is one of the most important. Complete understanding of the Los Alamos area health care environment will require further study into each of these factors.

Not all services can be sustained locally. Priorities need to be established based on benefits vs. cost. Some services that cannot be sustained locally need to be organized on a regional basis. UC/LANL needs to determine what services benefit it as an institution and provide funding outside the normal personal health insurance system.

Today, prescription medicines are the largest contributor to rising health care costs. Unlike services, medicines are a commodity, which provides more opportunity for free-market economics to control their costs. Present insurance plan rules requiring maintenance prescriptions to be obtained from specific out-of-state suppliers need to be reviewed to determine whether freer competition could reduce prices and help sustain needed local pharmacies.

In spite of the high-tech culture of Los Alamos, its medical community is not unusually advanced in the use of modern administrative information systems or in remote access to specialty medical services via telemedicine. These are two areas in which modest investments may lower costs or improve services.

Health care costs are going to keep rising. All of us need to understand the costs of our care choices and, more importantly, to make lifestyle choices that minimize the need for medical services. Medical professionals, employers, and insurers can help, but taking care of oneself is ultimately a personal responsibility

## Introduction

### Background

Health care services to meet most routine and some advanced medical needs have been available in the Los Alamos area for almost as long as the community has existed. In addition to basic medical care, an array of specialists have been directly accessible at the Los Alamos Medical Center (LAMC) and other medical facilities in the region. LAMC included a full-service acute-care hospital, one of three in the region. Costs have been tolerable for employers, who pay a large part of the total bill, and for consumers of the medical services. As a result, good local health care has been taken for granted and remains a major element of a high quality of life prized by residents. LANL and other institutions also feature it as a benefit to attract highly qualified employees.

Since the early 1990s, however, the scene has changed to one of continual turmoil. Costs to both employers and consumers have risen sharply. Insurance carriers and plans have changed frequently. Providers complain that they cannot make a living; some have left the community or even the practice of medicine. The feeling prevails that the quality, quantity, and stability of medical care in the community is threatened.

### Community Health Care Roundtable

The Community Health Care Roundtable (CHCR) was established in January 1998 “to assess the medical services and financial structures needed to provide quality health care to the Los Alamos community.” Los Alamos is not a closed community. Many people who work in Los Alamos live and get their medical care elsewhere. Many from the region get their medical care in Los Alamos, even if they have few other ties to the community. The issues are national, statewide, and regional. To make the complex problem as tractable as possible, CHCR has focused so far on medical care in Los Alamos itself and, to a lesser extent, in the surrounding area. CHCR’s focus is strategic and long-term. It has tried to avoid addressing details of specific current plans or practices.

CHCR includes providers (physicians, pharmacists, nurses, and therapists, etc.) and consumers of health care services, as well as representatives of major employers. It has met bi-weekly for over 18 months, has explored and discussed a wide range of health care issues, has talked with experts in the field, and has reached a consensus on some issues while identifying others deserving more detailed study. CHCR is not affiliated with or sanctioned by any other group or institution. While its members bring many perspectives, they do not formally speak for their employers or other groups with which they are affiliated. A list of members is included in Attachment 1.

This report has three purposes: (1) to educate by sharing what CHCR learned about the health care business as it affects the Los Alamos area, (2) to communicate

preliminary findings and recommendations, and (3) to indicate directions CHCR believes would be fruitful for further study. This report is interim in nature. Further study may change or expand the findings and recommendations contained herein. This report represents a majority view of CHCR members. As with the work of most committees, not every member concurs with every item within it.

## The Changing Face of Health Care

### National Trends and Issues

Most Americans enjoy the best health care in the world. But that care, and the increased length and quality of life it enables us to enjoy, comes at a price. Overall health care costs in the US rose at two to three times the general inflation rate for many years until slowing in the early 1990s. One factor behind that increase was medical technology's very success. Partially as a result of better health care, people now live longer but ultimately require more medical services. Other significant factors include duplication and overuse of some services, fraud, and malpractice litigation. Health care now accounts for more than 13% of the gross domestic product, and health care costs per capita are the highest among developed nations. The US is the only major industrialized nation that does not provide universal health care. More than 40 million Americans are uninsured and many are underinsured. As costs continue to rise, or when the economy turns downward, the ranks of inadequately insured will rise further.

Health care is the only personal necessity of modern American life largely paid through third parties: government and private insurance companies. Funds pooled by these entities come largely from taxes and employers, not directly from individual consumers. Consumers see only a portion of the real cost of health services and so are less motivated to economize. Because of this disconnect between consumer and payer, free-market forces do not operate efficiently and regulations are substituted.

The practice of employers purchasing health insurance for employees began in World War II, when wage controls prevented employers from offering workers higher salaries. The cost of employee benefits is a tax-deductible business expense for employers. Health care premiums paid by individuals are not usually deductible. Today, it remains less expensive for an employer to pay a major portion of the premiums than to increase employee salaries enough to pay the premiums and the income taxes on them.

Until the 1980s, most health care was paid through indemnity (fee-for-service) plans. Indemnity plans resemble traditional insurance, paying most or all costs above a usually modest annual deductible amount. Once that deductible has been reached, the consumer pays little or nothing for additional services. Indemnity plans allow the consumer to choose care from any medical provider with little regard for cost.

In the 1980s, many private health care plans began the transition to managed care. In managed care plans, a single primary care physician (PCP) directs an

individual's care. Referrals to specialists and other services are based on the PCP's judgment, insurer rules, and cost-containment incentives. Health maintenance organizations (HMOs), which may include both insurance and provider systems, are the primary vehicle for delivering managed care.

With the widespread transition to managed care, the rapid increase in health care costs slowed substantially. However, there is general agreement that the cost reductions brought about by managed care have been largely realized, and cost increases are again accelerating.

HMOs proliferated and were profitable while the transition to managed care was in full swing. Competition for new subscribers was fierce, helping to hold premiums down. But now that the nongovernmental market is approaching saturation, HMOs are consolidating, thus reducing competition. Many HMOs have lost money and are exerting pressure to increase premiums to remain in business. Maximizing shareholder return is a major driver of publicly traded HMOs, creating a conflict with the HMOs' mission of delivering low-cost, high-quality health care.

Generally, providers receive less compensation for serving managed care patients than they do under indemnity plans. Cost shifting is common in the industry. Providers competing for managed care contracts typically bid lower than what they would charge cash customers or those paying through indemnity plans. And much of their costs for serving the uninsured or underinsured are hidden in their charges to insured patients.

Governmental plans are also moving towards managed care, although they lag behind the private sector. Congress is discussing incorporating managed care into Medicare, the giant insurer of health care for the elderly. Many states have already adopted managed care for their Medicaid programs, which provide health care for welfare recipients.

Medicare is by far the largest provider of health care funding in the country. Although those over age 65 comprise only 12% of the population today, they use roughly half the medical services in the country. These percentages will grow substantially in the early decades of the next century as baby boomers reach age 65. This change in demographics will increase the demand for medical services. Although the number of doctors and other providers is increasing, it remains unclear how well supply and demand for health care providers will match in the coming decades.

Not all costs associated with managed care are financial. Although opinions differ on whether the quality of care is reduced under managed care, it is widely perceived that the "hassle factor" has increased. Usually employers choose insurance carriers, who then negotiate contracts with providers. As costs rise, employers seeking to reduce their costs often change insurers, which results in frequent changes in providers. These changes are disruptive to continuity of care and to sensitive relationships between patients and health professionals.

Like much of the rest of the economy, medical economics favor the higher volumes found in larger markets. As a result, services migrate to metropolitan areas. Lack of timely access to certain medical services, particularly emergency services, can be a life-or-death matter. Availability of service has always been a problem in rural areas. Now, many small- town hospitals are closing or becoming clinics. Even small city hospitals are under pressure. Although centralized services may appear less expensive, hidden costs to patients, employers, and society (e.g., time away from work, travel and waiting time, isolation of hospitalized patients from family and friends) are often not taken into account.

The health care system and its economics are complex subjects, and most consumers are bewildered by their workings. Nevertheless, consumers' understanding of their portion of premium costs and limitations on the providers they are allowed to choose is strong. Although managed care has reduced cost increases, the consumer is primarily concerned that the system "isn't what it used to be."

As consumers and providers began to feel powerless to effect changes in health care systems, they turned to government to regulate the industry. New regulations had a significant impact on reducing such abuses as the infamous "gag rules" contained in some early managed care contracts. Consumer backlash against reductions in choices and services under managed care continues to prompt various legislative initiatives, often referred to as "patient's bill of rights." These initiatives include providing the right to sue insurance companies for wrongful denial of treatment, mandating the availability of minimum levels of service, requiring specific tests, setting minimum length of hospital stays associated with certain procedures, mandating direct access (without a PCP's referral) to certain specialists, etc. Each "right," important as it may be, carries an additional cost to the system. The industry and the regulators must find a balance that is acceptable to consumers and providers. The challenge is to protect individuals without jeopardizing society's ability to provide for all of its members.

Roughly 35% of health care costs are for the 1% of population who have complex and/or multiple conditions. Another 30% is for the approximately 4% of the population who have chronic conditions. The last 35% covers the remaining ~95% of population that is generally healthy but has routine preventive and occasionally more specific needs. These distributions are found in both Medicare and younger populations. Managed care may best meet the needs of those with chronic conditions and those who need only occasional treatment or preventive health care.

The fastest growing component of today's increases in health care costs is prescription drugs. These costs are increasing at two to three times the rate of other medical services and now make up approximately 20% of health-care spending. (Hospital costs consume 40%–50% of the health care dollar; physician fees comprise 20%–25%.) Many prescription drugs cost significantly more in the US than in other industrialized countries, which have instituted price controls**.** Currently, the US

government is being pressured to also regulate these costs and to include prescription drugs under Medicare coverage.

As costs continue to rise, explicit rationing of health care services may be more seriously considered on a national level. The rationing issue is certain to be emotional and difficult. There is already one bold and reasonably successful model, the Oregon Health Plan, which was created four years ago to guarantee services to every resident living in poverty while keeping overall program costs within defined financial limitations. Briefly, Oregon's plan lists nearly 750 medical conditions and their treatments and prioritizes them based on perceived social value and effectiveness. For any year since, funds have been available to cover only up to about 600 of those services. Those above the "cutoff" in the priority list are covered that year. Those below it are not. Many deplored this "rationing" approach, but under it, services have increased and the plan is solvent. The state's decision to move from fee-for-service to managed care programs was crucial to the plan's success. Even with these savings, overall spending for the program has increased by 70% in four years.

One intriguing "new" approach to the practice of medicine holds considerable promise for bringing specialty services to smaller communities. Telemedicine links providers in rural or underserved areas with advanced medical resources in metropolitan areas throughout the country. As the Internet expands and develops, savings in both time and money can be achieved. However, the required initial investment is substantial, impeding more rapid implementation.

Other national issues include potential collective bargaining by more providers, the relationship between governmental regulation and quality of care, the ethics of care as delivered by for-profit vs. not-for-profit health care systems, and the growth of self-insured health plans which are subject to minimal, if any, oversight by state insurance regulators.

The economic environment of health care is ever-changing and subject to enormous political pressures. These pressures may lead to more governmental regulation and mandates to insurers to cover more care, to government-provided coverage for children and the uninsured, and to some expansion of the Medicare program to cover prescription drugs. Any of these steps will further increase costs and government involvement in health care. The ultimate result may be a tax-supported**,** single-payer system, i.e., universal health insurance, which would vest government with control of overall health policy and implementation.

## New Mexico Trends and Issues

New Mexico is experiencing all of the national trends, the impacts of which are influenced by the state's small and rural population and its weak economy. It has a higher percentage of uninsured and underinsured citizens than most states, which puts its entire health care system under higher-than-normal financial pressure.

Numerous reports have suggested that physicians are leaving the state or leaving the practice of medicine. These reports have not been confirmed objectively, but there are several conditions in New Mexico that make it less attractive to providers than many other states.

A national trend very much in evidence in New Mexico is the diminishing number of private insurers. At the national level, mergers are occurring in the name of efficiency and greater profitability. In New Mexico, the population is not large enough to support many insurers. As late as 1996, four HMOs were certified in New Mexico. Now there are effectively only two large insurers, Blue Cross-Blue Shield of New Mexico and Presbyterian Health Systems, who together lost $24 million last year. Two other active players, Lovelace and Cimarron, made $11 million. As a result of a recent merger, Qual-Med, may re-enter the New Mexico scene. In any case, the smaller the number of insurers, the weaker the bargaining position of both employers and providers.

Because cost containment is one of their major objectives, HMOs usually reimburse providers at a lower rate than indemnity plans. In New Mexico, where a large percentage of the population is covered by HMOs, fewer patients have the higher-paying indemnity plans that would help balance the providers' income.

New Mexico is one of only two states that applies a gross receipts tax on medical services. This tax does not apply to nonprofit medical providers (which include LAMC) but does apply to individual practitioners and profit-making corporate providers. In contrast to most other consumer goods or services, the gross receipts tax on medical services cannot be added to the consumer's bill. Reimbursement rates are usually based on a fixed national scale, and a gross receipts tax is a liability of the vendor, not the customer. Although the gross receipt tax constitutes only about 6% of the provider's gross income, it is a much larger percentage of net income since overhead for medical practices is typically around 50%. Hence a provider ultimately receives substantially less than he/she would for the same services in other states.

Regulation is extensive in the state, also. In 1998, the New Mexico Corporation Commission adopted an extensive set of rules for the state's managed health care industry. These regulations stipulate a number of quality controls and establish an independent appeals process for denied treatments. In 1999, they were incorporated in state law when the legislature passed the Patients' Bill of Rights. The Public Regulatory Commission (which replaced the Corporation Commission in 1999) collects a surcharge on most insurance plans to pay their administrative costs. As in other states, these regulations do not apply to self-insured plans, such as UC/LANL's.

Interest in a single-payer system is substantial here, too. In several recent legislative sessions, there has been an effort to place all New Mexicans under a single-payer, statewide health plan. The primary motivation is to provide coverage for the large number of residents who have no insurance. However, those who presently have broad, high-quality coverage could see their benefits reduced under such a system.

As elsewhere, physicians and medical services appear to be gravitating toward larger communities such as Albuquerque. Like the claimed exodus of physicians from the state, this migration has not been confirmed by data.

Los Alamos Area Trends and Issues

Although trends in health care delivery in the Los Alamos area are similar to those seen nationally and statewide, Los Alamos has a number of unique characteristics. Los Alamos County residents are among the best educated in the nation. Median income is among the highest in the nation, but so is the cost of living, which runs approximately 20% above the national average, mostly because of the cost of housing. Los Alamos County has relatively few uninsured or underinsured, but there is a large number in the surrounding region.

Since the 1950s, health care for the Los Alamos community has been centered at LAMC, which is presently operated by Lutheran Health Systems, a not-for-profit corporation that operates medical facilities in many other smaller communities around the country. Two other hospitals also serve the area: St. Vincent's in Santa Fe and the Espanola Hospital.

The area, especially Los Alamos County, is dominated by a single large employer, LANL, managed by UC for the US Department of Energy (DOE). Most residents of Los Alamos County, and many of the those in the surrounding region, are UC/LANL employees or are retirees or members of their families. The UC/LANL workforce is relatively stable. Many work at the Lab for decades then stay in the Los Alamos area when they retire.

UC/LANL has historically offered a comprehensive and inexpensive (to the consumer) health insurance package. Hence, most families opt for coverage through the Lab plan even if some family members are employed elsewhere. The result is that UC/LANL dominates nongovernmental coverage in the local market. However, Medicare is a significant insurer, and UC/LANL does not completely control the market.

Until 1993, UC/LANL employees (and retirees) were insured primarily through a traditional indemnity plan at low cost to the employee. Then the Lab introduced a managed care plan. By 1998, more than 90% of UC/LANL employees belonged to some form of managed care plan.

Approximately three-fourths of participants in the UC/LANL plans are active employees or members of their families. Of the one-fourth that are retirees, slightly over half are covered by Medicare. Those not in Medicare include retirees under age 65 and a few over 65 who choose not to participate. As expected, utilization of medical services by retirees is higher than by younger active employees and their families. For example, in 1997, the 25% of UC/LANL participants that were retired accounted for 48% of hospital admissions, 61% of hospital days, 33% of physician visits, and 44% of

prescriptions. In addition, UC/LANL have institutional needs for health care services, which include contractual requirements, emergency needs, specialized care needs (e.g., radiological), and levels desired for recruiting, etc.

Because of past UC/LANL hiring patterns and low employee turnover, the average age of the UC/LANL workforce and, hence, the community, is higher than the national average. Nearly half the present UC/LANL workforce is expected to retire in the next decade. Many of those workers and their families are expected to remain in the area, increasing the demand for geriatric health services.

UC/LANL employees and retirees use medical services significantly more than do Los Alamos residents not affiliated with UC/LANL. This is true even when UC/LANL and non-UC/LANL people are insured through the same company, go to the same providers, and have their care managed by the same primary care physicians using the same treatment protocols. It is difficult to determine whether UC/LANL employees are healthier because of their higher utilization of health care services. UC/LANL and its insurance administrators have made relatively little effort to determine whether usage is excessive or to control it.

On the other hand, UC/LANL personnel tend to use mental health and substance abuse services less than might be expected. Perceived risk to security clearances may be a factor discouraging UC/LANL people from seeking such services, or they may be paying for them out-of-pocket and not using benefits provided by their employer.

Cost per unit of service appears to be substantially higher in Los Alamos than elsewhere. Some of this difference can be attributed to the higher cost of living, higher cost of doing business, and limited economies of scale in Los Alamos. Costs are much higher at LAMC than at St. Vincent's Hospital in Santa Fe, an area with a similar cost of living. (It should be noted that LAMC disagrees with this characterization and asserts that the difference is simply in accounting methods.) Some difference may also be attributed to operational and management issues at LAMC, an area not yet explored in this study.

The gross (sum of employer and employees) premiums for the UC/LANL plans are higher than those of other major employers in New Mexico. However, the portion of total costs paid by employees and retirees is substantially less than that paid by employees and retirees of other large organizations.

The transition to managed care has been no less traumatic in Los Alamos than in other smaller communities in the country. The impact here has been substantial because of the greater reliance on specialists than in many other communities of similar size. In the past decade, the number of primary care physicians in Los Alamos has increased, and the number of specialists has declined. It is the latter that has attracted the most attention and concern. As is increasingly the case nationally, there has been much turnover. Some physicians have left for higher pay elsewhere. Some seek a different working environment. Some have moved away with their spouses, and

some have retired. The net loss of specialist physicians has been one general surgeon, one orthopedic surgeon, one psychiatrist, and one full-time urologist, who is now based in Santa Fe and still sees patients in Los Alamos one day a week.

Economics is a major issue in physician recruitment and retention. Provider income depends on three main factors: volume, reimbursement rate, and overhead costs. Managed care has reduced the demand for specialist services. Medical technology has reduced the need for surgery and in-patient hospital services. Reimbursement rates to providers are based on national or state benchmarks, which do not take into account the higher cost of living in Los Alamos or the gross receipts tax. Overhead costs for medical practices in Los Alamos appear to be higher than national averages. As a result, net incomes for Los Alamos physicians are lower than the national average for doctors, while the cost of living is Los Alamos is higher than the national average. Factors that sometimes help in recruiting new physicians to Los Alamos in spite of this economic squeeze are the lifestyles and natural beauty of community and the employment opportunity for spouses at LANL.

In some specialties, reduced volume has more than economic consequences. Proficiency can be adversely impacted if not enough cases or procedures of a given type are handled.

Some specialties, e.g., general surgery and orthopedics, require extensive on-call time for individual physicians. If demographics support only one physician in such a specialty, that person must either take all calls or split a full-time income in order to have a partner with whom to share calls.

The “hassle factor” of managed care affects physicians both locally and nationally. This term includes the higher cost, time requirements, and bureaucratic complexities of managed care. LANL’s current third-party administrator, Blue Cross/Blue Shield (BC/BS), is making an effort to improve administration of the health plan, recognizing that specific improvement in electronic communications technology is needed.

Los Alamos is in danger of losing “critical mass” in some specialties. This loss has already happened in urology and may occur in orthopedics in the near future. Some services, including general surgery and emergency service, do not pay for themselves but are clearly needed. At present, LAMC subsidizes these services.

Another factor affecting physicians’ ability to maintain their practices is the existence of three competing hospitals in a 50-mile radius. Although competition can be healthy, duplication of services is costly to the system. LAMC has operated in the black since 1987. St. Vincent’s financial losses and reductions in force have been widely publicized in recent years. Rio Arriba County (through a property tax mill levy) and Presbyterian Health Systems subsidize the Espanola Hospital to a combined total of roughly $4 million dollars per year. At some point, communities in this area may face a decision regarding whether to maintain these three institutions as they now exist.

## Challenges and Opportunities

Options for Structuring Systems

Employer-based group plans remain by far the most common model both in the country and in the Los Alamos area because premiums are tax exempt. Various structures for provision of health care coverage have been explored by employers, employer groups, and communities. However, few have shown that they are superior in saving money or in improving the quality of care.

Direct contracting has been tried in a few places. In this system, employers (or employer groups) contract directly with providers for services to their employees, eliminating the insurer middleman. This approach requires employer(s) to develop staffs and expertise in areas not related to their core businesses. There appears to be little evidence that this approach provides significant savings.

In provider-based systems, the providers (or provider groups) are also the insurers. This system seems to be declining in popularity and appears more suitable to a larger market than that offered by the Los Alamos area. Antitrust laws may apply in non-exclusive contracts if more than 30% of physicians in each specialty are in the same provider network. The networks must also share substantial financial risk to avoid anti-trust laws. Subdividing providers in the Los Alamos area would create groups too small to spread risks adequately. A handful of expensive cases could overwhelm the group's resources unless a substantial reinsurance plan were in place to handle these contingencies. Since a significant number of the more expensive cases are transferred outside the area, such a group would have a large pass-through and would not fundamentally change the system. This approach could create a two-tier system in which local providers handle routine health care, and catastrophic cases are sent elsewhere. The specific advantages of this system, in terms of costs and quality of care, are not clear.

Community-based systems put most residents in a community in a single insurance pool, regardless of employer. The primary advantage is more local control. A second advantage is the access afforded small employers and individuals to a larger risk pool. The overall risk pool may be larger than that of any individual employer. In Los Alamos, the pool would not be much larger than the existing UC/LANL pool, unless it was widely extended throughout Northern New Mexico. Local control would not be significantly enhanced.

Another alternative is to let individual consumers pay directly for their own routine medical care and use insurance to pay for the risks associated with major medical needs. UC/LANL offers such a plan, called "Core," but UC's contribution is not as large to this plan as to its managed care plans, and the deductible is impractically high for most non-Medicare participants. This type of plan could re-establish some of the efficiencies of a more normal vendor-customer economic relationship. It could

eliminate many of the hassles associated with third-party payment for routine care. Risks are associated with this approach when there are relatively few providers. Some members may postpone seeking care for purely short-sighted economic reasons. In an environment otherwise dominated by managed care, cost shifting to "cash customers" might occur. Individuals do not have the same clout to negotiate fees as do large health plans.

Prioritizing Specialty and Service Needs

It is not possible for medical centers the size of LAMC to be "all things to all people." Some commonly used services are financially viable if sufficient providers exist to carry out those services. Some, such as emergency care and generally surgery, are viewed as essential, and means must be found to support them. However, it is not possible to provide some specialty services locally. The need is simply not great enough to sustain local expertise. One possible conclusion is that the community will have to consider which medical services should be supported locally and which will be obtained elsewhere, a difficult and emotional task. However, it can be done in an objective manner with positive results as demonstrated in Oregon (Attachment 2).

**Findings**

Following are the Roundtable's findings to this point; these findings may change as more information and understanding develop.

1. Los Alamos is not unique. The transition to managed care has affected it in much the same way the rest of the nation has been impacted. What is unusual about the transition is the speed with which it happened. Since one employer dominates the local scene, the transition that took place nationally over a decade or two occurred in a much shorter time in Los Alamos, leaving less time for providers and users of health services to adjust.

2. Los Alamos still enjoys a broader range of medical services than most communities of its size are able to support.

*3.* Managed care has accomplished its principal objectives—delivering more care through primary care providers, reducing reliance on medical specialists, and lowering the rate of increase in medical costs. CHCR has found little evidence to date that managed care reduces the overall quality of care.

4. Health care costs are likely to continue to grow. It is unlikely that employers will continue to absorb these increases. Individuals will have to pay more attention to the total cost of their health care.

5. There is little true utilization management in the any of the health care plans in New Mexico, including those provided by UC/LANL.

6. Unlike medical care providers in 48 other states, individual practitioners and for-profit corporate practices in New Mexico pay a gross receipts tax of about 6%. This tax cannot be passed on to consumers or insurers.

7. UC/LANL employees and retirees utilize health care services more than other populations in the area.

8. Overhead costs of providers in Los Alamos appear to be higher than national norms.

9. Net compensation for providers in Los Alamos appears to be below national averages. This is in a locale where cost of living is approximately 20% above the national average, primarily because of housing costs.

10. Although medical science and technology continue to advance, utilization of modern electronic communications and business technology in the health care professions lags behind many other industries. Appointment scheduling, referrals, prescriptions, billings, etc., are often done essentially by hand. Lack of industry standards is a major impediment to more efficient and cost-effective administrative processes.

11. An inexpensive way to reduce health care costs is to promote healthy choices in habits and lifestyle. A large payoff appears possible with health promotion, but many insurers do not cover preventive treatments, e.g., smoking cessation and weight loss programs. The return on their investment is years or decades away when the consumer may be insured by someone else.

12. The current managed care environment is unsustainable. The national health care system is in transition to something not yet defined. Possibilities include a single-payer system. It is dangerous to focus local planning on a specific, current payment system. Long term, the focus needs to be on retaining the most needed services and on becoming adaptable to further changes.

13. No other financial structure or payment system has yet been identified that has demonstrated any potential to provide clear improvement over the current system in Los Alamos.

14. Although the UC/LANL health care plan represents a large portion of local health care business, it is not the only one. Many other employers and consumers exist in the area, and many individuals covered by UC/LANL or other employers are located outside the Los Alamos area. Any “experimental” program would be difficult at best.

15. Specialist retention is not solely an economic issue. Low volumes in smaller markets make it impossible to maintain proficiency in some procedures. The hassle factor of managed care is unattractive, and there are the same kinds of personality and employee satisfaction issues found in any work environment.

16. This area of Northern New Mexico may not be able to sustain three hospitals**.**

17. Substantial cost savings have not been proven for mail-order prescription services. Only local pharmacies can meet urgent needs, yet they are precluded in BC/BS plans from filling maintenance prescriptions that would help ensure their economic viability.

**Recommendations**

The following are CHCR's recommendations for consideration by the broader community. Many are recommendations for further study. CHCR will undertake some. LAMC, UC/LANL, or other entities are better positioned to pursue others. Community input is vital.

1. Consider desired types and levels of service for the community and the region. Determine which specialty services are needed and can be sustained locally and which are not medically necessary or economically practical to provide locally. Priorities should be established to guide future difficult decisions if it is not possible to sustain all services.

2. Determine what services are needed in Los Alamos or the area to meet DOE orders and LANL's programmatic needs. Those institutional needs should be funded by DOE/LANL directly and not indirectly through hidden costs to the normal personal health-care-financing system.

3. The value of medical services in recruiting and retaining personnel should be evaluated by UC/LANL and other employers.

4. Determine if charges for similar medical services are higher in Los Alamos than in Santa Fe and Albuquerque. If so, analyze causes (higher overhead, lower volume, etc.) for the disparity and determine which are controllable.

5. Specialty services that cannot be sustained at each facility in the region should be maintained on a regional basis.

6. UC/LANL and other employers should determine whether there is sufficient long-term return to justify increased funding for prevention programs (weight loss, smoking cessation, etc.).

7. Analyze the relationship between UC/LANL's gross premiums and its (high) utilization rates. A better balance may require either higher premiums or appropriate utilization controls.

8. Collaborate with state-level groups to determine whether there is a net drain of physicians and other health care providers from the state and the extent to which the gross receipts tax is a causal factor. If the gross receipts tax is found to be an

adverse factor in health care provider retention throughout the state, lobby for change.

9. Electronic processing of administrative functions in the health care delivery system, such as referrals and billing, would improve service and save several percent of the health care dollar. LANL (whose business is solving technical problems in the national interest) is encouraged to help apply modern information systems technology to this local and national need, either directly or through a corporate partner.

10. Telemedicine should be explored and encouraged for specialty consultations when insufficient volume exists to support the specialty locally.

11. Determine whether significant cost savings are achieved through mail-order plans versus purchasing at local pharmacies. If the savings are not significant, employers should be encouraged to structure their plans to promote local purchase.

12. Encourage UC/LANL to explore development of a "core"-type plan, which might offer features such as "purchasable" lower deductibles and stop-loss for the member. Assuming that an HMO plan were also offered, employees would have a true choice between fundamentally different plans. Analyze the effect such a plan would have on "cost shifting" in the system, promotion of preventive care, etc.

13. All consumers of health care services (which is all of us) must endeavor to understand more about the costs of these services and the trade-offs involved.

**Needed Information, Data, and Analysis**

The following information and data, potentially useful to further study of health care in the Los Alamos area, are needed, but have not yet been fully developed.

1. Demographic projections for the Los Alamos community. How many people in each age range are expected to be in the Los Alamos community in coming years?
2. Specific institutional needs of LANL. This information has been under development by LANL's ESH-2 for several months but is not yet available.
3. A complete survey of Los Alamos area employers to determine who is covered now, how, and at what cost. CHCR began such a survey but has not completed it.
4. More usage comparisons against similar populations. LANL's Human Resources Division continues to compile such data.
5. 1998 BC/BS utilization data for the UC/LANL plan.

## ATTACHMENT 1

### Community Health Care Roundtable

The Community Health Care Roundtable (CHCR) was established in January 1998 “to assess the medical services and financial structures needed to provide quality health care to the Los Alamos community.” For this purpose, the “Los Alamos community” includes Los Alamos residents, employees and retirees of Los Alamos businesses and institutions, their families, and neighbors who may receive medical services in Los Alamos. CHCR’s goals are to

1. Identify present and future health and medical care needs of the Los Alamos community.

2. Estimate the medical and financial resources required to meet those needs with various levels of service.

3. Identify and evaluate possible funding sources and management mechanisms for Los Alamos health care.

4. Foster communication and mutual understanding among those providing, using, or paying for health care and medical services in Los Alamos.

CHCR is an independent group of concerned volunteer citizens, neither formally sanctioned by nor affiliated with any institution. Its membership includes health care consumers, health care providers, and employers (who pay much of the bill). Staff support is provided by the University of California’s Office of the President. DOE’s Los Alamos Area Office has provided a regular meeting room. CHCR is grateful to both institutions for that support.

Present members of CHCR who participated in preparation of this report are listed below. Their affiliations are also listed for information purposes only. Members do not formally represent their institutions.

| | |
|---|---|
| Rosella Atencio-Gerst | LANL Benefits Team Leader |
| Betsy Barnett | Healthwatch; LANL Health Advisory Committee |
| Candy Bone | Pharmacist; Furr’s Pharmacy |
| M. J. Byrne | DOE-LAAO |
| Steve Czuchlewski | LANL Health Advisory Committee |
| Robert Gibson (chairman) | LA County Council |
| Sam Gibson | UC Office of the President |
| Wendy Hoffman | LAMC Administration |
| Richard Honsinger | M.D.; LA Physician-Hospital Organization (PHO) |
| Carolyn Linnebur | M.D.; LA physician, Medical Associates of Northern New Mexico |
| Karen Nelsen | LA County Employee Benefits Manager |

| | |
|---|---|
| Marja Springer | Chair, LANL Health Advisory Committee |
| June Wall | RN; Practice Manager, Medical Associates of Northern New Mexico; former LAMC Director of Surgical Services |
| Ken Wilson (vice-chair) | Laboratory Retiree Group; LANL Health Advisory Committee |

Others who have served at various times on the Roundtable include

| | |
|---|---|
| Mike Baker | LANL Director's Office |
| Jeri Bishop | Mountain Community Bank |
| Mary Rose C de Baca | LA Public Schools |
| Lori Coffelt | RN; LAMC ER nurse; Region Nine Nurses Assoc. |
| Kathy Garcia | RN; LAMC Director of Clinic Services |
| Ann Greene | JCNNM |
| Judith Kaye | LANL, Acting HR Director |
| Floyd Segura | LANL HR |
| Donna Vigil | DOE-LAAO |
| Dan Will | Mountain Community Bank; LAMC Board of Directors |

**Presentations to CHCR**

A number of individuals with special knowledge or expertise in health care delivery systems have taken time to speak with CHCR. Presenters and their subjects are listed below. CHCR appreciates the contributions of all.

4-22-98 Kimari Phillips, Research Associate and Project Coordinator, Health Promotion Center, University of California-Irvine, "A Social, Ecological Approach to Worksite Health Promotion"

6-24-98 Michelle French, Director, Health and Welfare, Office of the President, University of California, Oakland, CA "UC Health Plan Experience in Los Alamos"

8-12-98 Frances Menlove, Consultant Health Priorities Group, Berkeley, CA "The Oregon Health Plan"

9-30-98 Jacob Lawrence, Consultant The Segal Group, Denver, CO "Current Trends in Health Insurance Plans"

10-21-98 Dr. David Lorber/Gene Kersh, Medical Director/Manager

LANL Service Unit,NM Blue Cross, Albuquerque, NM
“Blue Cross Experience in Los Alamos”

3-3-99 Paul Wilson, Administrator
Los Alamos Medical Center, Los Alamos, NM
“Health Insurance Issues in Los Alamos”

3-31-99 Dr. David Lorber/Gene Kersh, Medical Director/Manager,
LANL Service Unit, NM Blue Cross, Albuquerque, NM
“Current Health Insurance Issues in NM”

4-28-99 Tom Short, Chairman
Los Alamos Medical Center Advisory Board, Los Alamos, NM
“Medical Services and Insurance in Los Alamos”

7-16-99 Michelle French, Director, Health and Welfare
Office of the President, University of California, Oakland, CA
“Trends in Health Insurance & Recent UC RFQ Experience”

## ATTACHMENT 2

### Prioritization of Services

The best-known prioritization scheme was implemented several years ago by the State of Oregon for their Medicaid system. The state listed nearly 750 medical conditions and their treatments and prioritized them based on perceived social value and effectiveness. For any year since, funds have been available to cover only up to roughly 600 of those services. Those above the "cut-off" in the priority list are covered that year. Those below it are not.

CHCR made an informal attempt to see how such a prioritization might be applied to determine what services are most valuable locally. The result is shown below. This is an example; it is not a recommendation. For this exercise, numerical weights were assigned to several factors to determine "need" and to determine "cost" of 55 representative medical services. The list was then arranged in the order of the ratio of the need to cost. Need factors included frequency and urgency of use. Cost factors included the amount of specialized knowledge and equipment required. Any serious attempt to use this approach would require much more thorough analysis and professional guidance (and a more complete list of services) than CHCR can provide.

**Example Prioritization of Health Care Services for the Los Alamos Area**

| SERVICE | NEED | COST | NEED / COST |
|---|---|---|---|
| **Primary Care** | 63 | 12 | 5.3 |
| **Pharmacy** | 57 | 11 | 5.2 |
| **Geriatrics** | 51 | 11 | 4.6 |
| **Drug Rehabilitation** | 31 | 7 | 4.4 |
| **Immunizations** | 29 | 7 | 4.1 |
| **Home Care** | 50 | 13 | 3.8 |
| **Psychiatry** | 42 | 12 | 3.5 |
| **Care Coordination** | 51 | 15 | 3.4 |
| **Pediatrics** | 44 | 13 | 3.4 |
| **Durable Medical Equipment** | 45 | 14 | 3.2 |
| **Dietary** | 28 | 9 | 3.1 |
| **Transportation** | 42 | 14 | 3.0 |
| **Ob/Gyn** | 68 | 23 | 2.9 |
| **Urgent Care** | 55 | 19 | 2.9 |
| **Endocrinology** | 46 | 17 | 2.8 |
| **Chemotherapy** | 33 | 12 | 2.7 |
| **Pulmonary/Allergy** | 30 | 12 | 2.5 |
| **Pulmonary/Cardiac Rehab** | 43 | 17 | 2.5 |
| **Ear, Nose, and Throat** | 30 | 12 | 2.5 |

| | | | |
|---|---|---|---|
| **Emergency Room** | 58 | 24 | 2.4 |
| **Cardiology** | 59 | 25 | 2.4 |
| **Lab/Pathology** | 64 | 27 | 2.4 |
| **Infectious disease** | 24 | 10 | 2.4 |
| **General Surgery/ Anesthesia** | 58 | 25 | 2.3 |
| **Massage Therapy** | 20 | 9 | 2.3 |
| **Occupational Therapy** | 18 | 8 | 2.2 |
| **Homeopathy** | 15 | 7 | 2.1 |
| **Chiropractory** | 42 | 21 | 2.1 |
| **Physical Therapy** | 29 | 14 | 2.0 |
| **Dermatology** | 37 | 19 | 2.0 |
| **Oncology/Hematology** | 22 | 11 | 1.9 |
| **Orthopedics** | 50 | 26 | 1.9 |
| **Cat Scan** | 49 | 26 | 1.9 |
| **Acupuncture** | 21 | 12 | 1.8 |
| **Rheumatology** | 20 | 12 | 1.7 |
| **Gastroenterology** | 32 | 19 | 1.7 |
| **Speech Therapy** | 22 | 14 | 1.6 |
| **Maternity Complications** | 39 | 25 | 1.6 |
| **Urology** | 24 | 15 | 1.6 |
| **Radiology** | 46 | 30 | 1.5 |
| **Neonatology** | 36 | 25 | 1.4 |
| **Vascular Surgery** | 35 | 25 | 1.4 |
| **Opthamology** | 34 | 24 | 1.4 |
| **Back Surgery** | 24 | 18 | 1.3 |
| **Sports Medicine** | 32 | 24 | 1.3 |
| **Dialysis** | 38 | 30 | 1.3 |
| **Hand Surgery** | 25 | 20 | 1.3 |
| **Podiatry** | 14 | 11 | 1.3 |
| **Radiation Therapy** | 34 | 30 | 1.1 |
| **Neurology** | 23 | 21 | 1.1 |
| **MRI** | 28 | 26 | 1.1 |
| **Restorative Rehab** | 29 | 28 | 1.0 |
| **Nephrology** | 20 | 22 | 0.9 |
| **Plastic Surgery** | 14 | 19 | 0.7 |
| **Bone Densitometry** | 19 | 30 | 0.6 |
| **Infertility** | 11 | 20 | 0.6 |

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